EXECUTIVE INSIGHTS

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FINANCIAL RECOVERY AND FORECASTING POST-COVID-19

C-level Perspectives on What's Ahead

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C-level Perspectives on What's Ahead

America's hospitals and health systems have faced unprecedented financial pressures due to the COVID-19 pandemic. This year many are still navigating the net financial impacts, including revenue losses and additional expenses incurred to meet personal protective equipment and testing needs. This executive dialogue examines ways health care provider organizations are adjusting budgeting and forecasting practices, ensuring flexibility and productivity going forward, and reimagining care for the communities they serve.

KEY TAKEAWAYS

1. Depending on their patient and bed characteristics, many hospitals are facing revenue losses due to COVID-19 and creating recovery plans that can help them address staffing, burnout and bed availability.

2. Hospitals and health systems are transforming their financial forecasting into more dynamic methods to watch their operating margins more closely in shorter time periods and promote flexibility amid uncertain waves of the pandemic.

3. Availability of resources and emergency funding is disproportionate across hospitals, making it a challenge for financial leaders who are fully knowledgeable about the financial impact to their hospitals.

4. Health systems are aligning internal resources and structure to facilitate digital platforms and new ways of working remotely, and rethinking the supply chain and staffing models with shifts in care delivery.

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MODERATOR: **Suzanna Hoppszallern**
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MODERATOR: *(Suzanna Hoppszallern, American Hospital Association):* **How is your organization adjusting its financial planning and forecasting strategies in light of the pandemic? How did 2020 change your hospital budgets going forward?**

PAUL EVES *(Southern Humboldt Community Healthcare District):* Our critical access hospital is located in a very remote town in Northern California in the redwoods; the nearest hospital is 55 miles to the north. We have the only emergency department (ED) for a total of 120 miles on Highway 101, so our existence is critical to the area. COVID-19 hit us hard because in mid-March, we stopped seeing any patients in our provider-based rural health clinic altogether. However, within three days we established a telehealth capability, and from mid-March through beginning of July, all of our clinic visits were via telehealth. We postponed every preventive health-related visit for that time period. Obviously, Medicare reimbursement for telehealth clinic visits is a fraction of face-to-face clinic visits, so revenue was affected in that way.

Additionally, visits to our ED declined due to two factors. The first was the greatly reduced number of tourists visiting the area, and second, our community was good about sheltering in place after

the county public health officer asked county residents to stay indoors for the spring and early summer months. As a result, the ED experienced a reduction by approximately half for early spring months through the early summer months.

DWAIN STILSON *(Mosaic Health System):* We are a four-hospital system between Kansas City, MO, and Omaha, NE, with a critical access hospital, a smaller regional 80-bed facility, a long-term acute care facility and a 350-bed tertiary facility. In December 2019, our organization transitioned from a static budget process (we have a June 30 year-end), to a more dynamic rolling forecast. In hindsight, the timing was perfect, because in mid-March COVID-19 hit.

Our current financial planning process gives us the flexibility to say, 'You know what? ... Things have come back a little bit, not all the way, and it allows us to reset.' It's more dynamic, but all of us are dealing with a high degree of uncertainty. You bring in uncertainty and risk, and the variability increases while the ability to estimate with a degree of confidence goes down.

MIKE BLAIR *(CentraCare):* CentraCare, in central Minnesota, is an eight-hospital system, with one large tertiary center, and we have mostly smaller rural hospitals that extend into the western part of the state. We're into a second surge right now, which is more severe than the first. We're working collaboratively with all the health systems in Minnesota as to where we have open beds; however, most are pretty stretched. We're almost hitting our capacity in terms of intensive care beds and regular beds. The fear is that if this doesn't subside and we have a severe influenza season, it's going to be a challenge.

In the first surge in the spring, which wasn't as severe, we reduced the amount of capacity. Then we began a road to recovery on how to reopen the system. How do we ensure we're providing care for those patients who need care but aren't getting it?

Toward the end of September, we started seeing a significant increase in the number of COVID-19 patients. First, our patient acuity increased significantly. Part of that is because some individuals still remain resistant to coming into the health system. Many lower acute procedures weren't occurring. Second, many acute-status patients who should have been hospitalized three months earlier, now are in the hospital in a much more advanced stage of illness. Third, we've also seen an increase in the acuity of some of the COVID-19 patients.

MODERATOR: When you look at your forecasts and your financial planning, do you assume that you're going to keep on this trajectory and that 2021 will be on par to where you were in the past?

EVES*:* Yes, economically speaking, our bread and butter has been Medicare swing beds. Swing-bed patients disappeared because the hospitals north and south were not doing any elective surgeries at all. And yet, we started seeing people in the clinic on July 1. Our clinic visits are up and our ED visits have returned to near normal volumes. Our patient volume has recovered quite quickly, and I wonder if that isn't a characteristic of a critical access hospital. The people in this community and in the district as a whole need our services, and some have a two-hour drive just to get to our facility.

It is impossible to predict the number of ED visits or acute stays. However, we do have some control over swing beds. A few years ago, the state legislature mandated that all hospitals in California must meet seismic standards. That requirement is effective starting Jan. 1, 2030. We have about nine years to build a new hospital, and the total population of our district is only slightly more than 10,000 people. We've already purchased the property, and we are in the process of making architectural and engineering plans. I'm optimistic about our future.

MODERATOR: Is the trajectory also coming back? Are you in the recovery mode that you started in May?

"We provide ongoing financial performance updates, with and without the COVID-19 impact, and keep our eye to the future so we're able to react to changes like those we're seeing now, such as staff burnout."

— Mike Blair —

STILSON*:* In the Midwest, we didn't feel the big pressure in cases early on, but we saw a drop in volume. We created the capacity and it remained empty. We brought it back up when it was safe in May and June. Right now, in the Midwest, we are experiencing our peak. Just recently, the number of COVID-19 inpatients in our facilities was in the 90s. With 499 beds available, we're running at 300-350. Now we're revisiting conversations that others on the East Coast may have had in March. ED and surgical volumes are still down, compared with those of the prior year. Overall, we've made some reductions in our expense platforms that have helped to offset some of that.

Outpatient visits are down, but we've seen a significant increase in our virtual (telephone/video) visits. There is more volatility, and it is more challenging to predict our mix of patient services. Our outpatient/inpatient mix has gone from a 50/50 mix seven to 10 years ago down to a 40/60 inpatient/outpatient mix. It's reversed in the past six months, and about 42% or 43% is inpatient.

BLAIR*:* From a planning perspective, we set our baseline plan and then we stepped back and asked how we'd like to perform in a normal world. We then layered on various scenarios in terms of what could happen regarding COVID-19, and what could happen with a severe economic downturn. Part of this was to prepare the board to understand how much variation there could be in this year's financial performance, and similarly with the employee base. Once the employee base understands, everybody has to focus on delivering those baseline items, but we also have to recognize that, depending on a second COVID-19 surge, it could change the picture significantly. We provide ongoing financial performance updates, with and without the COVID-19 impact, and keep our eye to the future so we're able to react to changes like those we're seeing now, such as staff burnout. They've been going at this for a long time. We have 1,200 employees who either have COVID-19 or have been exposed to it or are caring for somebody who has the coronavirus. That is about 10% of our staff. The other 90% has to cover for those 1,200 people, pick up another shift and work overtime. We're going to have to pay what it takes to get those shifts covered.

LORI DENNIS *(First American Healthcare Finance):* From a national perspective, some who have been doing one-year or even five-year budgets are now looking at 90 days at a time because there's so much uncertainty. There are many questions about the CARES Act provider relief funds, especially with coverage and how much you get to keep. The reporting certainly adds another layer of complexity to what is already going on. How do you keep people healthy and keep all the shifts covered?

MODERATOR: How does your organization need to pivot in the next 12 months to make up for lost revenue due to delayed or canceled procedures and surgeries?

BLAIR*:* The challenge we have right now is that we were in the middle of trying to transform the system and improve our financial performance. We had some solid plans in place that would get us to a solid operating margin. The problem is trying to execute that right now when staff are worried about having enough beds for patient transfers, and whether we can get these individuals into a hospital in the Twin Cities if we run out of beds.

It's a balancing act right now. When we first dealt with COVID-19, we started discussing the need to start

thinking about how to get past the surge and get the health system back open, our road to recovery. As part of the road to recovery, we referred to a 'road to results,' and the need to begin focusing on our future transformation, and instill this mindset into everybody as we look to the future. This progress was challenged with the arrival of the second surge. When the second surge starts dialing back, we can return to the road to recovery.

It's going to push some of our work out even further, and we don't know if there will be multiple waves. It's going to depend on what happens with the dissemination of the vaccines. If we don't see another surge, just smaller waves, then we'll focus on getting back to that transformation work as soon as we can.

STILSON*:* Approximately 75% of our patients are self-pay, Medicaid and Medicare. During the economic downturn, our local economy didn't experience as significant an increase in unemployment due to its heavy manufacturing employment mix. Our payer mix has been more heavily impacted by long lengths of stay. On the clinical side, we need more nurses to care for the same number of patients because they're here longer.

We are seeing an increase in our case mix (acuity), but not enough to offset all of the additional costs. With the higher costs, greater risks and higher degree of uncertainty, we're working to gain enough assurance that our operating margins will remain as such that we are able to continue to reinvest those funds in our high-quality clinical programs.

We're taking this opportunity to improve administrative processes (thereby reducing costs), and let the clinical folks know that while they're out there fighting on the front lines, we're still focused on supply chain, revenue cycle and other critical support functions to position the organization more favorably into the future.

MODERATOR: **Mike, are you in a similar situation where you're trying to achieve clear visibility into the future?**

BLAIR*:* Right now in the middle of the second surge, it's hard to maintain a focus on the future. We're trying to keep certain work groups focused on digital transformation work underway. We're trying to make sure that this work continues and also recognize that some of our clinical partners may have to take a hiatus from that work for a while. We are trying to keep at least one eye focused on what comes next. We, and a lot of other systems, are worried about what's going to happen after we go through the COVID-19 surge and how people will take care of their health needs.

On a positive note, for example, we worked on telehealth for two years and couldn't come up with a solution. And then, when we had no choice, we did it in two weeks. We are reminding everybody that this is how we have to think in the future. We can always find 1,000 reasons why we can't do something or why it needs to take longer. With telehealth, we proved to ourselves that we could get a difficult project done quickly.

MODERATOR: **How are you continuing to expand your footprint? What does your investment in virtual technologies look like? What other investments are you considering?**

BLAIR*:* Part of it is recognizing that the care model must reflect patient preferences. My guess is that there always will be a significant number of patients who want to be seen in person, and that's OK. We need to provide that avenue. There's also a sizable segment of the population who would prefer virtual visits.

We also need to improve the virtual visit experience. For example, after check-in, the nurse talks to you and 10 minutes later, the doctor joins in. The same things that frustrate people about going to an in-person visit were replicated in the telehealth experience. We need to work through those processes.

STILSON*:* We've created a new group within our information technology team called Digital Platforms. We've reassessed the structure within our technology and innovation area to put resources toward devel-

oping a true digital plan. We're trying to put a greater emphasis on our app, our web, our portal, and also making structural changes from a leadership standpoint to support that as a key priority.

DENNIS*:* We've heard a lot of people talking about rethinking how much real estate they need. How many seats do you need in the building? Maybe we just don't need to put as much money into real estate and offices. Are your organizations talking about that? Is there going to be a more permanent work-from-home aspect as part of a bigger picture?

BLAIR*:* We're definitely talking about that, and we believe some will permanently move to working from home. We're also considering a blend of working from home a couple days a week. What we miss is the collaborative brainstorming, but you can do it through Webex or Microsoft Whiteboard. It doesn't seem to elicit the same creativity you achieve when you're in a room together and you're using process flowcharts and diagrams. We're thinking about how we can incorporate this process into a blended model.

Think about what the auto industry is going through as they transform from gas-powered cars to electric, or the printing and publishing industry, as they went from print to digital. There are some similarities to what we're trying to do with telehealth. And you can't duplicate the overhead or the resources, or you're going to fail, because it's the same dollar. You're just delivering that dollar through a different method. We have to be conscious of that.

STILSON*:* Some of the pressure we're under is that funds saved from working at home are going into maintaining inventory. We have more inventory now than before, and we're all stocking up because what we used to use in a year, we're using in a month.

In terms of working from home, we recently surveyed about 400 people and between 15% and 20% prefer to stay at home forever, 15% to 20% want to return to the office five days a week, but the majority of individuals want to be on-site one or two days a week where they can collaborate, with the convenience of going back to their home location.

"We've reassessed the structure within our technology and innovation area to put resources toward developing a plan that is a true digital platform. "

— Dwain Stilson —

MODERATOR: **Have you or are you making permanent changes to deal with COVID-19 for the long term?**

STILSON*:* It's going to take a while for us to get back to a just-in-time inventory, as one example; cash that used to be invested is now sitting on shelves in distribution centers. We have made or are planning to make critical investments in our ED as well as our intensive care unit. Additionally, we plan to have at least 20% of all of our beds pandemic ready.

BLAIR*:* We have to think about how to run as lean as we can on some of the personal protective equipment. We're also thinking about the staffing model — how to engage nurses who have retired, and exploring options to keep them on a part-time basis, or finding more individuals from local tech schools who are interested in being nursing assistants.

STILSON*:* All of our great plans sound brilliant in isolation and within our regions until Mike and I start competing for the same nursing resources. Then our plans are contingent on staffing, and potentially compromised because Minnesota is competing with Missouri, which is competing with Washington, D.C., and San Francisco. That is something with which we all have to figure out how to wrestle.

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